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ABSTRACT

Low literate patients face difficulties when they read health care information. The complex process of reading can be summarized in five steps: input, decoding, encoding, output, and feedback. Each occurs automatically for the fluent reader; the low literate reader might encounter stumbling blocks in one or more of the steps. Once the patient has the written material in hand, the senses--visual, auditory, and tactile modes--become involved. The health care professional should be aware of the sensory input level of the patient, which may impede the desired communication. Once the input step occurs, decoding or the word recognition stage begins. A dilemma for many low literate people is a lack of strategies for recognizing words. The alert health care professional might ask the patient to point out words recognized on a brochure or explain a brochure verbally and circle important words. A key to the next step, encoding or comprehending the information, is to help patients access prior and personal knowledge about the new health concept. Strategies include the following: K-W-L or "What I Know, What I Want To Know, and What Have I Learned"; graphical organization of the information; and guided discussion. The next stage, output, typically involves oral or silent reading and is less important with low literate readers than the previous stage. The crucial feedback stage involves thinking about new information and knowing when one understands and when one does not. The sensitive health care professional can help the patient by thinking aloud. (Contains 10 references.) (YLB)

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HEALTH CARE COMMUNICATION WITH LOW LITERATE PATIENTS

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| The Reading Process | Stimulus | Input | Decode | Encode | Ouput | Feedback | Bibliography |

The Joint Commission of Accreditation of Health Organizations (JCAHO) has recognized the importance of effective communication with patients. The 1993-1994 and 1994-1995 guidelines for accreditation include scoring on how well patients understand health care information (Doak, Doak, and Root 1996). The 1993 National Adult Literacy Survey, on the other hand, indicates that forty to forty-four million adults have low literacy skills. Since communication involves literacy, namely reading and writing, it makes sense, that the health care profession consider these areas in its attempt to communicate effectively with all patients, including those with low literacy skills.

Furthermore, widespread cultural diversity nationwide places demands on effective communication with the culturally different patient. The 1993 National Adult Literacy Survey reports that Black, American Indian/Alaskan Native, Hispanic, and Asian/Pacific Islander adults are more likely to perform in the lowest two literacy levels than Caucasians.

In order to give the reader an appreciation for the difficulties faced by low literates, this paper explains what might happen when such a patient reads health care information. It also addresses what has been done to improve effective communication with low literate patients and suggests alternative ways to communicate with them.

THE READING PROCESS

There are many models which attempt to explain the complex process of reading. In order to understand the multitude of difficulties that might face a low literate, however, the reading process can be summarized in five steps: Input, Decoding, Encoding, Output and Feedback. Each area occurs automatically for the fluent reader; the low literate might encounter stumbling blocks in one or more of the steps.

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Prior to actually reading, there is an assumption that there is something to be read. Patients confront reading materials in a variety of forms: admitting papers, informational brochures, prescriptions, discharge papers, surgical consent forms, menus, living wills, to name a few. The stimulus is whatever the patient may be asked to read.

INPUT

Once the patient has the written material in hand, the senses become involved. Typically, the senses involve the visual, auditory, and tactile modes. Vision involves, not only acuity, or the ability to actually see the page, but also the ability to discriminate between letters, words, numbers, pictures, or whatever is on the page. The low literate patient might have poor acuity. The National Adult Learning Survey (1993) reports that 19 percent of those adults performing in the lowest literacy level indicate having visual difficulties that affect their ability to read print. Doak, Doak, and Root (1996) give excellent guidelines for evaluating the suitability of print, including layout, graphics, and typography. For the culturally different patient, the visual might lead to other difficulties. The printed language may of course interfere, but attention needs to be drawn to the content of the visuals, particularly graphics. The patient may be offended, for example, by pictures which indicate meat-eating as a suggested dietary component if meat-eating is not part of his culture. Once again, Doak, Doak, and Root (1996) give clear guidelines for helping the health care professional accommodate the culturally different patient.

The auditory mode, on the other hand, may give the patient difficulty (McCormick 1991). Perhaps the patient has not actually heard the directives. This involves hearing acuity. Using visuals or demonstrations may solve this problem. Having the patient retell the information makes sense. The practitioner can then informally assess what is heard.

For patients whose English is not the primary language, it is recommended that the health care professional speak slowly, make sentence structure simple, avoid technical terms, and provide information in a logical sequence (Tripp-Reimer and Afifi 1989). The health care professional should also be sensitive to variations in dialect. Assessing one's own attitude toward cultural differences is important to insure that the health care professional does not allow personal attitudes to interfere with the communication (Randall-David 1989).

The third mode of communication is the tactile, which involves writing. Reading and writing are very connected skills. The National Adult Literacy Survey (1993) reports that 66 to 75 percent of the lowest level adults perceived themselves as being unable to read or write well or very well. Ninety- three to 97 percent in the second lowest level reported the same. Low literate patients are faced with a myriad of writing tasks ranging from signing one's name or filling out a menu to completing admissions and insurance forms, although the world of computer technology has helped here. Not only does the low literate have difficulty reading the information, but often, he does not know how to write health related information. The "if you answered YES please explain" type questions are problematic. Having patients dictate or otherwise record information via checklists are two solutions which may accommodate the situation. Other family members might also assist in the task.

In summary, the health care professional should be aware of the sensory input level of the patient. This may impede the desired communication.

DECODE

Once the input step occurs, keeping in mind that this process occurs instantaneously for the fluent reader, decoding begins. This is the word recognition stage. Patients have a number of ways in which they recognize words. Some will know words from sight or memory; words such as "exit," "ladies room, ' "x-ray." Other patients may attempt to sound out the words, using a phonics approach. Many words in the English language are not phonetic, however, and this may not work. Words such as "patient," "medicine," and "surgery," for example, do not follow any consistent phonic rules. Another way of approaching a word is to see a part of it as familiar. A patient might recognize "lab" in the word laboratory," or "diet" in the word "dietitian." Another strategy is to use the context of the situation. For example, a patient might look at the word "steak" on a nutritional brochure and presume to know the word because of an accompanying picture; however, a patient might also look at words with no pictures on a menu and assume the same word is "stew."

A dilemma for many low literates is this lack of strategies for recognizing words. Often they have sight words which they have memorized to "get by," but they are not skilled in other ways to recognize words which they have never seen.

The alert health care professional might ask the patient to point out words that are recognized on a brochure. Explaining a brochure verbally to the patient and circling the important words to develop a sight vocabulary might be another way. Helping a patient predict what the words of importance are based on the context of the situation would also be appropriate. For example, a low literacy patient confronted with discharge papers might be asked to look at the following directions: "no driving, no steps, no heavy lifting." Circling each of the phrases and giving contextual clues as to the meaning could be helpful. A health care professional might address the first directive by indicating that it relates to transportation, thus, no driving. By circling the words for the patient and discussing the meaning, the patient is actually learning a phrase by sight.

In an attempt to confront the word recognition level of printed material used in health care settings, many health care professionals use readabililty formulas. The SMOG formula and the Fry formula are two popular ones and at least twelve other languages have formulas for readability. In addition to assessing material using a formula, however, other factors need to be considered. Doak, Doak, and Root (1996) developed a suitability assessment of materials instrument (SAM), which takes the factors of content, literacy demand, graphics, layout and typography, learning stimulation, and cultural appropriateness into consideration. Once assessed, it may be recommended that the printed material be rewritten on a lower level to accommodate the low literate patient, or alternative methods of communication may be necessary. The AMC Cancer Research Center (1994) and the National Cancer Institute (1992) developed guidebooks which include action oriented exercises such as role playing, theater, storytelling, visual aids, and videos.

The next logical consideration in the matter of word recognition is to determine who the patients are with low word identification skills. The Rapid Estimate of Adult Literacy in Medicine (REALM) is a quick assessment of patients' word recognition ability (Murphy, Davis, Long, Jackson, and Decker 1993). Whether or not this assessment is used, keen awareness as to how a patient approaches words is necessary if communication is to take place.

ENCODE

Keeping in mind, once again, that the fluent reader automatically processes and understands print in one swift movement, the next step in understanding the process is that of encoding or comprehending the information. Not only do patients need to identify words, but they must also understand them and be able to apply the new health concepts to everyday life. Understanding print is a complicated matter. Research has recognized that there is much more to reading information than simply identifying or pronouncing words.

A key to helping patients understand new information is to help them access prior knowledge and personal feelings about the new health concept. One strategy that might work well is the K-W-L or the "What I Know, What I Want to Know, and What Have I Learned" idea (Vacca and Vacca 1996). This approach uses brainstorming and a sheet of paper with three columns, one for K, one for W, and one for L. To implement the brainstorming, the health practitioner asks the patient what he or she already knows about the topic. The brainstorming occurs as the health care professional writes in the first column all information recalled by the patient. In this way, the practitioner helps the patient to think as well as assesses how much to instruct. Considerations about misconceptions on the part of the patient can be learned in this step. It is important that the health care professional place any misconceptions in the context of the patient's background experience, including the context of any culturally different beliefs. Rather than being judgmental, the practitioner must appreciate differences when instructing the patient. Randall-David (1989) provides a useful document which outlines the cultural beliefs of the Amish, Asian Americans, Black Americans, Haitians, and Hispanics and Latinos.

After helping the patient recall background knowledge, the next step is to elicit what the patient would like to know about the health concept. As the health care professional writes these concerns in the second column of the K-W-L sheet, an informal assessment of what needs to be taught takes place. The practitioner fills in the gaps necessary for accurate understanding of the essential information needed to benefit the patient. By having the patient retell the information and recording it in the third L column of the paper, the health care professional assesses what the patient understands. Reteaching the patient occurs if need be. By using the K-W-L strategy, the health care professional organizes information for the patient in the context of prior knowledge and essential knowledge for good health.

Another technique is to graphically organize the information for the patient. By illustrating the necessary information either with pictures or in a chart format, the health care professional outlines the essential concepts. Vacca and Vacca (1996) provide a useful selection of graphic organizers which demonstrate ways to reach learners ranging from cause and effect maps to semantic maps which help patients understand the related aspects of health concerns.

Guided discussion is yet another way to reach a patient. Using this approach, the health care professional lists several

concepts to be learned, discusses them with the low literate patient, and asks the patient to summarize the concepts grasped. The health care professional can assess if new information is understood by using this strategy. However, whether or not the patient attends to the issue in everyday life is another matter. The practitioner needs to help the low literate take ownership of the new information and apply it to his life. Again, graphic organizers, very simply written, can help here; however, the health care practitioner needs to be sensitive to the patient's life style and the practicalities involved in carrying out any plan. Low literate patients do not automatically internalize new information. Mentoring needs to occur.

In summary, understanding new concepts in health care for low literates is a complicated task. It should embrace past experiences, present points of view, and practical applications depending on the person.

OUTPUT

This stage of reading typically involves oral or silent reading. Having a patient read information orally might be appropriate in some cases; however, the primary purpose of reading should be to understand the new concept. The teaching strategies mentioned in the previous section make more sense than to simply hand the patient a brochure or other printed material, have him read it, and assume that the information has been internalized.

FEEDBACK

This stage of understanding is crucial. Feedback involves thinking about new information and knowing when one understands and when one does not understand. For the low literate patient, knowledge of one's own understanding may not be evident. The sensitive health care professional can help the patient by thinking aloud. When the practitioner shares what he knows, he can encourage the patient to do the same. Adult learning involves ownership of one's learning. When the health care professional reaches the patient on such a level, true patient communication will occur.

In summary, the health care community desires to communicate effectively with all patients. Patients with low literacy skills and those of culturally different backgrounds provide the health care professional with unique challenges. This paper attempted to provide those working with such patients with a framework for understanding the process of reading. An appreciation for the difficulties faced by those who have minimal reading skills will, hopefully, assist the health care professional to effectively communicate the health care information.

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